

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2009
---	---	--	---

NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from June 25, 2009 through June 26, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: Interview with the the facility's Qualified Mental Retardation Professional (QMRP) on June 26, 2009 at 4:52 PM and review of the training records verified that the physical therapist trained the staff on June 19, 2009. At the time of the survey, however, the facility failed to ensure direct care staff were effectively trained to teach Client #3 to use and to make informed choices about	W 189	<p><i>Reviewed 7/21/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <p>W189</p> <p>All staff were in serviced on the use of adaptive equipment (Chest Harness) on individual's (#3) Wheel chair</p>	7/06/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Swan L. Stan</i>	TITLE <i>Operator</i>	(X6) DATE <i>7/22/09</i>
--	--------------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 189	Continued From page 1	W 189	W189		
W 356	<p>wearing a chest harness for her safety. [See W436]</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive dental treatment services necessary for the maintenance of dental health for one of the three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>Review of Client #1's medical record on June 26, 2009 at 2:10 PM revealed a dental consultation dated January 26, 2009. The dental consult reflected that the dentist had diagnosed the client with large deposits of plaque and calculus on all surfaces of her teeth. Additionally, the consult indicated that the client's oral hygiene was very poor. Scaling was recommended to be performed after authorization was obtained. The client returned to the dentist's office on March 31, 2009 and May 4, 2009, and was informed that they had not received the preauthorization for the scaling.</p> <p>Another dental consultation dated June 6, 2009, revealed adult prophylaxis with polishing was performed, however, the recommendation for the client to receive full mouth scaling continued not</p>	W 356	<p>In the future the QMRP will ensure that all staff are trained in safety precautions and adaptive equipment and that the Residential Coordinator will monitor staff daily.</p> <p>W356</p> <p>In the future the QMRP and Nursing staff will ensure that dental recommendation is completed on a timely manner.</p> <p>See attached dentist statement</p>	7/08/09	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 356	Continued From page 2 to be addressed.	W 356			
W 436	<p>Interview with the facility's Licensed Practical Nurse (LPN) on June 26, 2009, revealed the facility had been experiencing difficulty with getting preauthorization for dental services. According to the nurse, the facility was in the process of finding another dentist, but in the meantime, Client #1 was scheduled to be seen again by the same dentist in September 2009.</p> <p>At the time of the survey, the facility failed to ensure Client #1's dental health was maintained.</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients was taught to use and to make informed choices about the use of the devices identified by the interdisciplinary team as needed by the client for one of three clients(Client #3) included in the sample.</p> <p>The finding includes:</p> <p>Observation of Client #3 on June 26, 2009 at approximately 10:30 AM, revealed the client arriving at her day program. The client was observed in a wheelchair being accompanied into</p>	W 436	<p>W436</p> <p>Refer to W189</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	<p>Continued From page 3</p> <p>an open space area. Further observation revealed the client wore molded shoes, had her wheelchair seatbelt secured, but no other adaptive equipment was observed.</p> <p>Review of Client #3's medical record on June 26, 2009 at 4:33 PM, revealed a physician's order dated May 2009. Continued review of the order revealed the client required the use of a chest harness/seat belt for safety.</p> <p>Observation throughout the survey on June 25, 2009 and June 26, 2009 revealed Client #3 not wearing the recommended chest harness. Interview with some of the direct care staff on June 26, 2009, revealed that they had seen the client wearing a chest harness sometimes, and other staff had no knowledge of the harness.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on June 26, 2009 revealed that Client #3 had a chest harness. Additionally, the QMRP indicated that she recalled the client wearing the chest harness on June 19, 2009, when the facility's physical therapist conducted training. Continued interview with the QMRP on the aforementioned date, at 4:52 PM revealed that she spoke with the physical therapist on the day of the survey to ascertain information regarding the client wearing a chest harness. According to the QMRP, the physical therapist informed her that Client #3 should be wearing the chest harness at all times as ordered for her safety.</p> <p>At the time of the survey, the facility failed to ensure that Client #3 safety harness was available and worn as prescribed.</p>	W 436	<p>W436</p> <p>Refer to W189</p>		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1 000	INITIAL COMMENTS A licensure survey was conducted from June 25, 2009 through June 26, 2009. A random sample of three clients was selected from a resident population of six women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	1 000			
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties for six of the ten records reviewed. The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2009, at 5:42 PM and review of the personnel records revealed that the GHMRP failed to provide evidence that	1 206	1206 In the future the QMRP and HR Department will ensure that all employee records are updated according to policy. See attached health Certificate	7/10/09	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0000

03H811

TITLE

(X6) DATE

If continuation sheet 1 of 4

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 206	Continued From page 1 current health certificates were on file for three direct care staff and three consultants. This is a repeat deficiency from the survey conducted on May 30, 2008.	I 206			
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was effectively trained in the area of adaptive equipment for one of three clients in the sample. (Client #3) The finding includes: Interview with the the facility's Qualified Mental Retardation Professional (QMRP) on June 26, 2009 at 4:52 PM and review of the training records verified that the physical therapist trained the staff on June 19, 2009. At the time of the survey, however, the facility failed to ensure direct care staff were effectively trained to teach Client #3 to use and to make informed choices about wearing a chest harness for her safety. [Also see Federal Citation W436]	I 229	W1229 Refer to W189		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 401	<p>Continued From page 2</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive dental treatment services necessary for the maintenance of dental health for one of the three residents (Resident #1) included in the sample.</p> <p>The finding includes:</p> <p>Review of Resident #1's medical record on June 26, 2009 at 2:10 PM revealed a dental consultation dated January 26, 2009. The dental consult reflected that the dentist had diagnosed the resident with large deposits of plaque and calculus on all surfaces of her teeth. Additionally, the consult indicated that the resident's oral hygiene was very poor. Scaling was recommended to be performed after authorization was obtained. The resident returned to the dentist's office on March 31, 2009 and May 4, 2009, and was informed that they had not received the preauthorization for the scaling.</p> <p>Another dental consultation dated June 6, 2009, revealed adult prophylaxis with polishing was performed, however, the recommendation for the resident to receive full mouth scaling continued not to be addressed.</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) on June 26, 2009, revealed the facility had been experiencing difficulty with</p>	I 401	<p>W1401</p> <p>Refer to W356</p>		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1401	Continued From page 3 getting preauthorization for dental services. According to the nurse, the facility was in the process of finding another dentist, but in the meantime, Resident #1 was scheduled to be seen again by the same dentist in September 2009. At the time of the survey, the facility failed to ensure Resident #1's dental health was maintained.	1401			

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

5:50

03H811

TITLE

(X0) DATE

If continuation sheet 1 of 2

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER METRO HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 125	Continued From page 1 checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for four staff.	R 125			